

# Health and accessibility needs of the Chagossian community

Improving local services and health outcomes following demographic change



**citizens  
advice**

**in West Sussex**  
North South East

September 2025

# Executive Summary

This NHS-funded research project marks an important milestone in our commitment to reducing health inequalities and amplifying the voices of a local community group with unique and often overlooked needs. Led by our local charity, the project has not only generated critical insights into barriers to healthcare access but has also created lasting impact through training staff in Community Participatory Action Research (CPAR), laying the foundation for a sustainable legacy of inclusion, learning, and system change.

Through deep community engagement, the project has provided a vital platform for individuals facing complex challenges, including housing insecurity, financial hardship, unemployment, and language barriers, to share their experiences and help shape future services. This has led to a clearer understanding of the hierarchy of needs, where practical day-to-day challenges often take precedence over health, despite the community's willingness to engage with healthcare services.

A second key finding highlights the difficulties of navigating a pressured and fragmented health system, compounded by systemic delays, inaccessible pathways, and deep-seated mistrust, the result of both lived experience and perceived gaps between expectations and system capability. These challenges underscore the urgent need for more person-centred, responsive, and culturally sensitive healthcare models.

Importantly, the research process revealed strong community appetite for contributing to positive change, with many participants offering thoughtful, community-led recommendations. Their input has shaped a compelling case for adopting an empowerment-based approach, one that builds capability and confidence at individual, neighbourhood, and system levels.

Our key recommendation is to embed empowerment as a core principle in healthcare delivery, increasing access to services, supporting self-advocacy, promoting prevention, and ultimately reducing health inequalities at a generational level. This project demonstrates that when communities are empowered to lead, real and lasting system change is possible.

I am grateful to the funders for this opportunity and our community for giving their time to this, and I am very proud of our incredible engagement team with this work.

**Emma Cross**

**CEO, Citizens Advice in West Sussex (North, South, East)**

# Introduction

The Chagossian community are an island people from the Chagos Archipelago in the Indian Ocean, whose origins on the Islands date to the 1790's. Despite a complex history of contested sovereignty, the community developed a strong cultural identity with deep connections to their homeland through social and economic networks.

In 1965, the British Government formally established the Islands as a new colony, known as the British Indian Ocean Territory (BIOT). Between 1968-1973, the Chagossian population were forcibly removed from the Islands to support the development of a United States military airbase. This has resulted in the continued exile of the Chagossian people from their homeland.

The displaced population and their children were granted British, Mauritius and Seychellois citizenship. Since a new UK citizenship route was introduced in 2022, Crawley, West Sussex, has become home to the largest Chagossian population in the UK, with over 3,500 individuals settling in the town.

Crawley is the most ethnically diverse area in West Sussex, with 38% of the population identifying as an ethnic minority, having increased since 2011. The town is also the most deprived area out of the seven towns in West Sussex, experiencing high rates of poverty and economic inactivity. Notably, one ward ranks within the top 10% most deprived areas in the UK. The local economy was further impacted during the Coronavirus pandemic, as the collapse of the travel industry affected the Gatwick Diamond, a key transport and business zone and a major source of employment for local residents.

Deprivation and health inequalities are closely linked, with populations lacking basic needs such as shelter, food and income often experiencing poorer health and wellbeing outcomes. Like other migratory populations, the Chagossian community has typically been overrepresented in deprivation measures both abroad and in the UK. Complex language and cultural barriers, combined with deep rooted mistrust towards the British Government, means that access to services often relies on community leaders and support networks. Without this support, engagement can remain challenging, leading to unmet need and highlighting the importance of tackling social determinants of health to improve community wellbeing.



# The research team

Citizens Advice in West Sussex (North, East, South) is an independent local charity and member of the network of Citizens Advice charities. We provide accessible information and advice on the problems people face so they can make informed decisions and move forward. We are a learning organisation with a twin priority to use insight to influence and change the system so the root cause can be addressed, and community voice can shape the solution.

The researchers, listed below, drew on their lived experience and trusted relationships within the community to carry out this research. Their background and connections supported meaningful and culturally sensitive engagement with community members.

- Amy Marshall – Insight, Reporting and Development Officer
- Catalina Gheorghe – Community Engagement Officer
- Tessa Ramrajsingh – Chagossian Community Liaison Officer



# Aims and objectives

This research explored whether migration changes to an area's demographic makeup created new accessibility or service needs. Working with the Chagossian community, the project aimed to understand:

- How individuals manage their health and wellbeing
- Navigate daily responsibilities
- How individuals interact with local services

Guided by the insights, feedback and experiences gathered throughout the project, the research ensured that a range of diverse voices were heard and existing relationships strengthened. It also helped build new connections with individuals who do not usually engage with organisations or whose perspectives are not always included.

The research identifies approaches to empower the community so they can take charge of their health, encouraging services to be built by the community and for the community so that people can thrive.

These insights deepen understanding of individual behaviours and unmet needs, informing service design, accessibility and wider health outcomes. They will also be used to drive future NHS policy and local service delivery, as well as support the wider system in meeting the needs of an underrepresented group but whose experiences may be applicable to other communities.



# Methodology

## Context

This research was conducted within a developing international situation. In May 2025, sovereignty negotiations over the Chagos Archipelago concluded, with expected changes to immigration law that may influence migration patterns and place additional pressure on local services.

These international developments intersect with local challenges, including stretched budgets and services operating beyond capacity, increasing pressure on delivery. In February 2024, Crawley Borough Council declared a housing emergency in response to unprecedented demand for temporary accommodation. The ongoing high cost of living has further impacted living standards and demand for public services.

## Research design and approach

The research was conducted over ten months, using a Community Participatory Action Research (CPAR) approach, delivered through the NHS Workforce, Training and Education Programme. Active community engagement shaped both the research process and their participation, reflecting the community's priorities and preferences. The flexible design allowed ongoing community input to guide the project's direction, while an informal approach helped address mistrust and reduce barriers to participation. A mixed method approach also supported diverse engagement needs, including questionnaire's, semi-structured interviews, workshops and ongoing engagement.

The projects broad scope involved continual engagement with community members, leaders and local services to better understand their needs and experiences. An internal steering group was established to soundboard ideas and monitor progress throughout the project.

**citizens advice** in West Sussex  
North South East

### La sante cominoter chagossian - Ou avis important

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**Ou kave aide nou...**

1. Compren lexperiens ki bann chagossian ine ggner avec nhs aide nou
2. Identifier bann bariere ki exister entre zot avec service nhs

Kan ou p partisiper nou but cest creer ene comprehension bann aksesibiliter de bann nouvo cominoter.

email nou lor sa lien la si ou interesser:  
[community.engagement@westsussexcab.org.uk](mailto:community.engagement@westsussexcab.org.uk)

**NHS** England South East

**University of Reading**

**sedc** scottish community development centre

# Collecting insights

## Community members

Community engagement began at local events identified through existing connections, initially using a questionnaire to gather background information on health service use. However, community feedback highlighted that language barriers and limited opportunity to share personal experiences reduced its effectiveness.

The main form of engagement was through outreach sessions and community events such as the Chagossian lunch club, which provided informal opportunities to hold everyday conversations and build trust. Researchers attended these sessions several times a week. The presence of Citizens Advice in West Sussex to support the community's wider needs around housing, benefits and education helped to address the social determinants of health and reinforce trust.

The research also engaged with key community leaders from advocacy groups, including:

- Chagossian Elderly West Sussex
- Chagossian Voices
- Chagos Action Alliance Committee

Their insights into the community's history and shared experiences helped shape early understand and the research focus.

In the latter stages, researchers created separate spaces for more personal stories, including eight semi-structured interviews and two workshops with 21 participants. Themes included mental health, maternity and emergency treatment. While translation was supported by the Chagossian Liaison Officer, language barriers still reduced participation in some group settings.

A review of 86 service users from the Citizens Advice in West Sussex database provided further insight into the complex experiences faced by community members living in the UK.



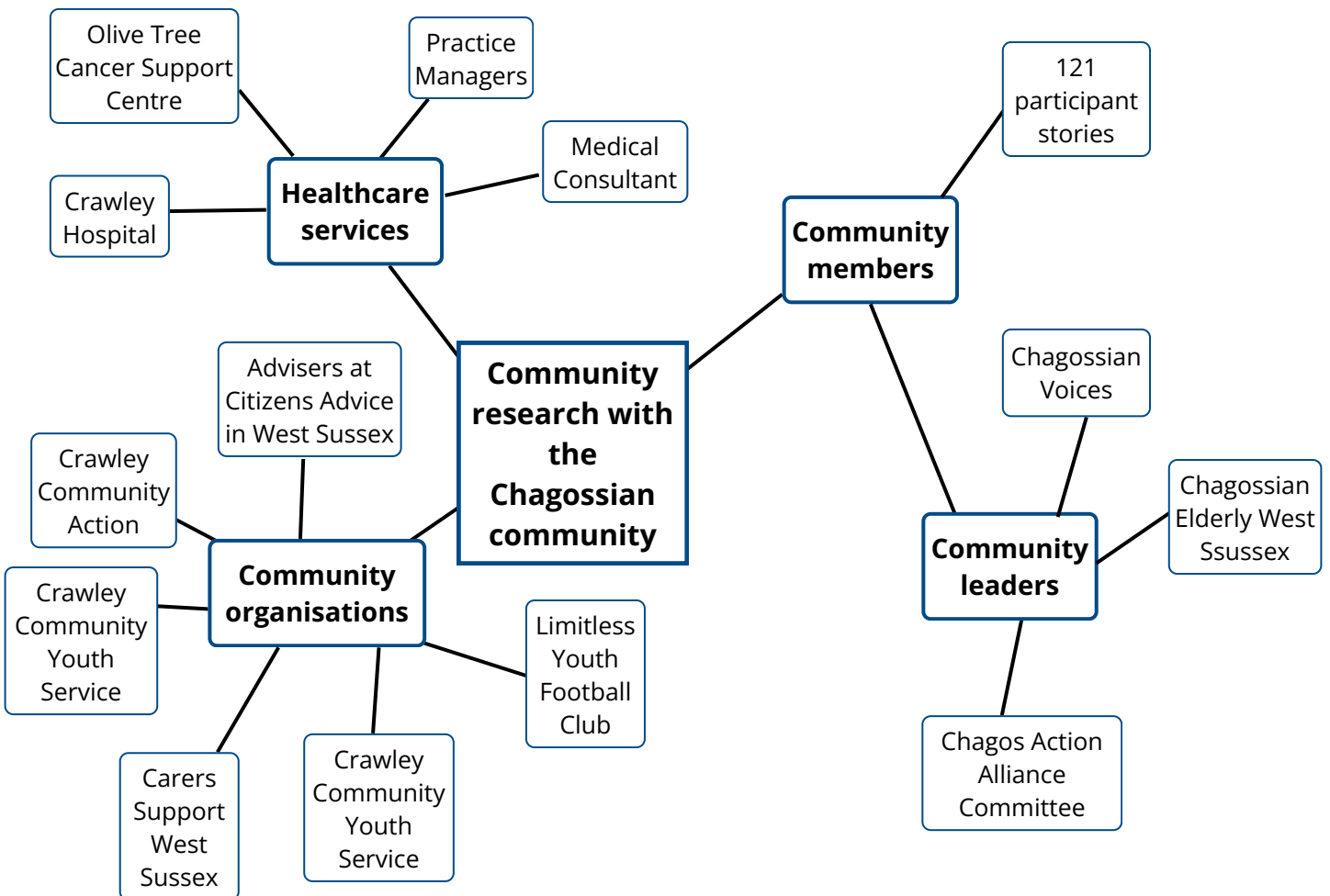
# Collecting insights

## External engagement

Researchers also engaged with local organisations and service providers, including:

- Crawley Community Action
- Crawley Community Youth Service
- Crawley Hospital, including the onsite Cancer Support Centre
- Carers Support West Sussex
- NHS medical consultant
- Practice Managers from General Practices in Crawley

These discussions broadened understanding of the local context, service capacity and demand. They also highlighted opportunities for more preventative and holistic approaches across the wider system.



# Collecting insights

## Challenges

Some common challenges associated with community research emerged during the project. Language barriers and unfamiliarity with the research process affected engagement and some individuals were unable to participate due to personal responsibilities or time constraints. Despite this, researchers were able to build trust and gather meaningful insights over time.

We found the informal approaches that CPAR allow often produced greater engagement and better quality insights which is a learning to take forward.

## Analysing insights

The insights gathered were predominantly qualitative, drawn from the stories and experiences shared with researchers. Key information from these narratives informed a thematic analysis that shaped the projects main findings.

Core themes also supported the collection of quantitative data. However, due to inconsistencies in recording, workshop and event insights were excluded from this analysis. As a result, while the project is based on 121 stories, quantitative data relates only to the 94 individuals engaged through interviews or as service users.



# Findings

## Overview of Health in the Community

The findings highlight a high prevalence of complex and often long-term health conditions within the Chagossian community, many of which are being managed alongside instability and wider social challenges. While experiences vary, many participants described overlapping difficulties that compounded their ability to meet basic needs or achieve personal goals. Even small changes in circumstance could have significant impacts on their health and wellbeing.

The project recorded these conditions based on the information participants chose to disclose. As health details are self-reported they may not refer to a clinical diagnosis but they provide an indicative profile of the community's health:

- HIV
- Various types of hepatitis
- Cardiovascular conditions and diseases such as diabetes and high blood pressure
- Neurological conditions such as epilepsy
- Physical impairments such as paralysis, mobility issues, sciatica, arthritis and back pain
- Special educational needs and disabilities (SEND), including autism and ADHD
- Specific cancer types
- Visual impairments
- Hearing impairments
- Tuberculosis
- Substance misuse and alcoholism
- Mental health conditions such as anxiety, depression, and stress

The severity and duration of conditions varied, from temporary illness to permanent disability. While some were in recovery or receiving treatment, others described being permanently unable to work.

The thematic findings that follow explore these health challenges in greater depth, alongside wider accessibility needs and behaviours.



**56%**  
of people disclosed a  
health condition or  
disability

# Findings

## 1. Hierarchy of needs

Early findings revealed that urgent basic needs, such as housing and food, were often prioritised over health, particularly among recent arrivals facing significant instability. Many experienced housing insecurity, including overcrowding, eviction threats, unsuitable living conditions and rough sleeping. These conditions affected people's health where some participants with mobility issues struggled to access upstairs rooms, impacting their ability to maintain hygiene, prepare meals or leave their home. Others, including children, reported worsening asthma or respiratory problems due to damp and mould. Sofa surfing was also common, often linked to overcrowding and relationship breakdowns. Anecdotal evidence suggested that the time required to become settled has increased.

***"I haven't had any appointments or treatment for my cancer since last year. I can't sleep at night because I'm scared it's getting worse. I'm so tired." - A community member***

A significant proportion of individuals lived in temporary accommodation, including hotels and B&B's. While this offered short-term relief, many described factors of unsuitability:

- Lack of cooking and washing facilities
- Presence of antisocial behaviour and concerns over safety
- Out of area accommodation could mean people face higher living costs as well as increased transport costs to school or work, difficulty maintaining healthcare appointments and interference with waiting lists

Alongside housing, food insecurity, immigration status and unstable income were key concerns. Some relied on foodbanks which made it difficult to meet dietary needs related to health conditions. This pattern of behaviour reflects Abraham Maslow's Hierarchy of Needs, where physiological and safety needs must be met before individuals can focus on health and long-term wellbeing.

These overlapping pressures often led to delays in treatment, missed medication, managing poor working environments and deterioration in existing conditions. It



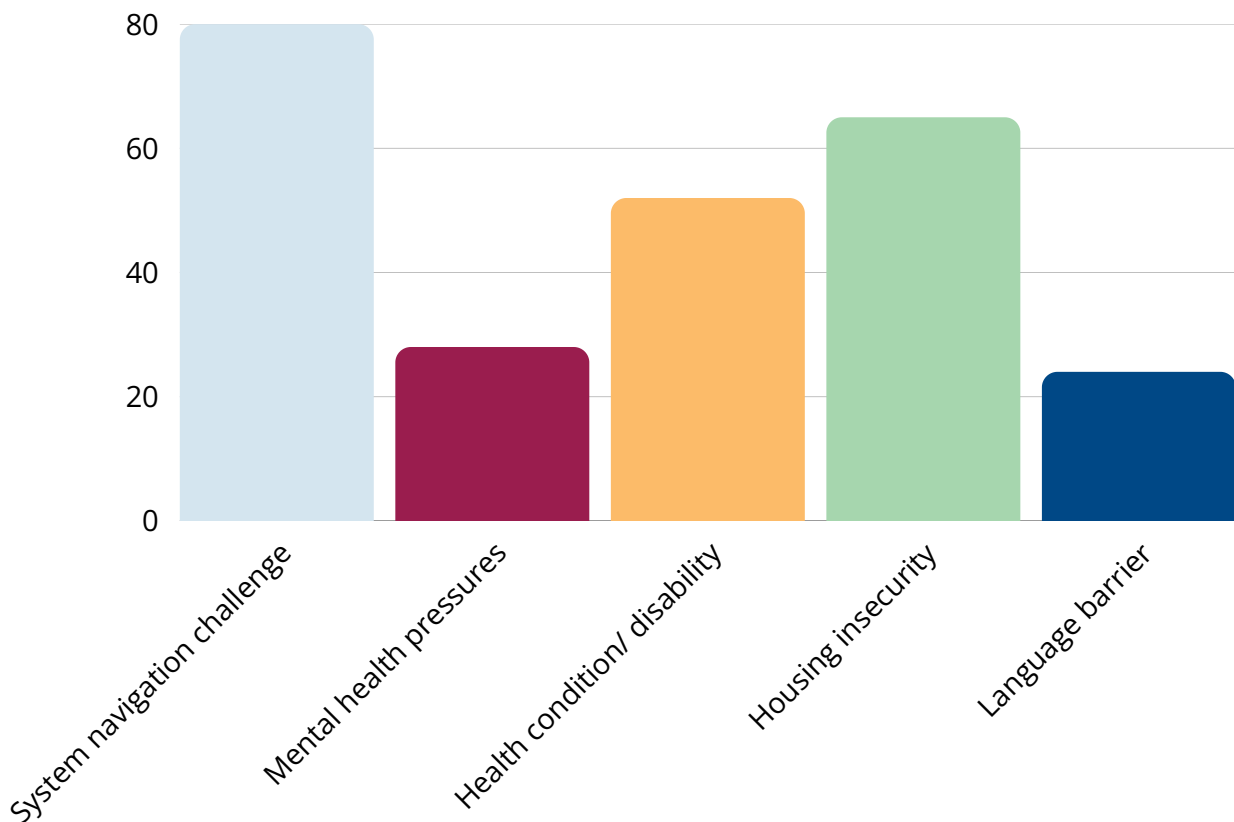
**70%**  
**of people experienced  
housing insecurity**

also placed further pressure on wider system responses, particularly when eligibility to public funds was restricted.

Notably, the community did not dismiss their health concerns or view them as unimportant. Untreated health problems caused significant stress for individuals and community leaders recognised the impact of the pressures associated with survival.

However, this theme highlights how unmet socioeconomic needs can impact health outcomes and increase reliance on services.

### Key themes identified



# Case studies

## Hierarchy of needs

Participant A is married with young children. The family were placed in out of area, temporary accommodation while they searched for more permanent housing. Their current accommodation was in severe disrepair. One child was hospitalised with respiratory issues while another was undergoing treatment for epilepsy.

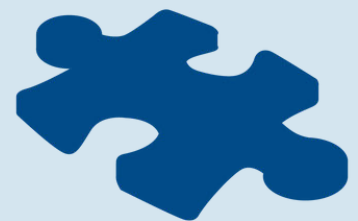
Despite serious health concerns, housing instability and financial insecurity took priority. Without a fixed address, they were unable to access key medical documents and had to rely on charitable grants to meet basic needs. The family have since been rehoused in a hotel by the Council. This case highlights how immediate survival needs often take precedence over managing health and wellbeing.



## Impact on health

Participant B migrated to the UK as a British citizen seeking better healthcare and was living with multiple long-term health conditions, including HIV. After arriving, he was diagnosed with additional complex illnesses. When his initial supply of HIV medication ran out, he went without treatment for several months due to difficulty accessing a GP which severely compromised his immune system. His wife is now his full-time care, however he has not told his wider family due to stigma.

Challenges with housing, finances, and navigating services have further impacted his health. Placed in out-of-area accommodation, he faces high travel costs for hospital care. His PIP claim was rejected due to residency rules, and digital and language barriers have made managing his Universal Credit claim difficult. Without an income, he now relies on foodbank vouchers. Despite this, he reports positive experiences with NHS staff and finds appointment and medication reminders particularly supportive.



# Findings

## 2. Navigating unfamiliar systems and processes - practical barriers

The most consistent challenge community members face in managing their needs and responsibilities is navigating different systems and processes, either due to individual knowledge and capability or broader, structural issues.

At the individual level, limited understanding on individual rights and responsibilities often made navigation challenging. For example, missed opportunities to reduce costs and avoid financial crises were common, such as the inability to pay the immigration health surcharge and offset medical bills, and the unawareness of rent, utility and council tax charges. Difficulties also occurred in completing follow up tasks, like filling out a benefit application or understanding hospital letters. Low digital literacy and confidence further compounded these challenges. This uncertainty contributed to increased stress, leaving many without the support they were entitled to.

Many also lacked the confidence or skills to self-advocate, particularly in clinical settings. This was worsened by intersectional issues, including women being dismissed as overly tired or anxious and in one case a misdiagnosis of sepsis on dark skin. Some also described culturally insensitive care or clinical hesitancy, where professionals appeared reluctant to investigate further for fear of causing offense. These experiences left individuals feeling unheard and inadequately supported.

Some participants reported pregnancy not being identified which may suggest future exploration of sexual health knowledge amongst some residents is needed and professionals recognising that some communities may feel less able to self-advocate or know how to explain symptoms to a health care professional.

**86%**  
people faced a barrier  
to accessing a service  
or required support  
to do so

# Findings

## 3. Navigating unfamiliar systems and processes - sociocultural barriers

System navigation was also shaped by community sociocultural factors:

- Word of mouth remains a trusted way to share information amongst many members which can build confidence but also contribute to misinformation. For example, some avoided healthcare after hearing of charges they would not have faced themselves while others arrived in the UK with misinformed expectations on support.
- Cultural expectations that did not align with NHS processes also influenced engagement. Some individuals expected same day appointments or faster responses, leading to frustration and disengagement.
- Mental health pressures were a recurring theme. Many individuals described high levels of stress, anxiety, and trauma which was often linked to isolation, disrupted family life and the emotional strain of adapting to life in the UK whilst balancing cultural identity and integration. Parents raised concerns about the impact on children's wellbeing and school performance.

### ***“She goes to school every day feeling anxious” - A mother on their child's experiences at school***

- Stigma, particularly around mental and sexual health, further discouraged open discussion and seeking support, particularly as mental health is not always recognised as a legitimate concern. In the community's matriarchal structure, men were often less able to express or act on their own health needs.
- Strong mutual support exists, with many taking on informal caregiving roles, including children. While this helps address service gaps, it can affect individual autonomy and dignity, while also limiting opportunity for work or self-care, placing further strain on caregivers.



# Case studies

## Barriers to independent navigation

Participant C is a pensioner with a progressive neurological condition. She received a letter demanding repayment of a large debt in a single lump sum, with the threat of tribunal action. She was visibly distressed, unaware of what the debt related to or how to respond. She also could not use email and had limited access to digital information.

With support from an adviser, she was reassured and no longer had to face the situation alone. The adviser liaised with the Council to clarify the debt and arrange a sustainable repayment plan. This case highlights how digital exclusion and uncertainty about responsibilities can create further problems that affect wellbeing.



## Barriers to independent navigation

Participant D has multiple health conditions, including cardiovascular and respiratory issues and cannot speak English. After briefly leaving the UK due to a bereavement, she returned to an eviction notice at her temporary accommodation. Unaware of the reason and unable to manage complex benefit processes alone, she had several incomplete applications and missed key deadlines.

Despite submitting medical evidence, which was not returned, and being declared unfit for work by her GP, she was advised to seek employment. Her inability to self-navigate the system without support led to severe stress, panic attacks, and a hospital admission.

Only after an adviser intervened was her eviction delayed, allowing her time to access support, complete her applications, and secure a stable income. She has since moved into permanent housing near her support network and is receiving mental health care.



# Findings

## 4. Failure Demand

Individual capabilities were further challenged by inconsistent, complex and under-resourced systems. While services were under high demand, many structural challenges limited access to support and positive health outcomes:

- Administrative complexity often delayed progress. Many individuals faced issues beyond their control, such as not receiving a National Insurance number, passports held by the Home Office, no fixed address for correspondence, or the need for a UK-based guarantor which all created barriers to completing applications.
- Delays across systems were common. Long waits for benefit decisions, immigration outcomes, or housing placements left people with uncertainty, unable to access vital services when they were most needed and impacting on their mental health.
- Financial pressures added to this instability. Rising childcare and housing costs, high visa and immigration fees placed further burden on people. Some also experienced discrimination linked to their legal status which could increase health inequalities.
- Both inaccessible communication and assumptions on individual ability can increase the likelihood of people falling through the cracks. Medical letters and official documents were often in English making them difficult to understand or follow and a lack of follow up care, particularly after involvement with social care, contributed to isolation and unmet need. Embedding links to translation sites would help overcome this.

### ***“It is a constant battle of survival” - A workshop attendee on their life in the UK***

- Limited service capacity further constrained support. Cuts to youth services reduced safe spaces and training opportunities, while low availability of one-to-one support and fragmented specialist care increased the time, cost and effort required to access help.
- Some policies do not consider individual needs or circumstances. For example, the Habitual Residency Test can prevent individuals from accessing support without accounting for their unique historical circumstances. Likewise, families rehoused by the Council, lost access to child benefits due to disrupted school attendance.

These barriers reflect a two-way interaction where the difficulties individuals face, influence how they engage with services, which in turn shapes the level and quality of support they receive.



# Case studies

## System barrier

Participant E is a British citizen with young children. He manages complex conditions including cardiovascular disease and mobility issues due to paralysis. After moving address, he independently registered with a GP but was told to find a closer GP, with no clear instructions on how to do this.

When he became unwell, Participant E called an ambulance as he had not been able to register with a new practice. Whilst he appreciated the quick emergency response, he continues to face barriers accessing appropriate care due to limited, accessible information. He receives monthly blood test results via phone but struggles to interpret them and is not confident using online services. A lack of clear guidance on how to access different types of care, such as physiotherapy, specialist services, and financial support for medical needs, has made it difficult for him to manage his conditions effectively.



# Recommendations

The findings reflect the complex and layered experiences of the Chagossian community, highlighting both shared and specific barriers to accessing healthcare and essential services.

Improving accessibility and health outcomes will require targeted individual support alongside broader system level changes. These recommendations are rooted in lived experience and aim to build on community strengths through empowerment, helping to reduce health inequalities.

## Individual-level recommendations

Activity should focus on building individuals knowledge, confidence and skills to navigate services independently and take greater control of their lives. This includes access to language classes to reduce reliance on interpreters and support individuals to self-advocate and address low confidence.

## Neighbourhood-level recommendations

Neighbourhood-level changes can enhance this by improving how information and support are delivered. Neighbourhood health centres, as outlined in the NHS's 10-Year Plan, offer a key opportunity to build local services that are responsive to community need.

These centres can act as trusted spaces for learning and engagement, using plain language and visual tools to explain rights, available support and how systems work. They could also offer culturally safe, practical workshops that builds peoples vocabulary on system phrases and keeps communities informed about key healthcare developments, such as Martha's Law which gives carers the right to request a second opinion.

## System-level recommendations

At both neighbourhood and system levels, stronger partnership working is essential to better align community organisations with statutory services. A whole system, holistic approach is key to addressing interlinked needs across health, housing, education and more, helping to ensure that every contact counts.



# Conclusion

This research has aimed to capture the nuance, layers and complexities within people's stories, recognising that each experience is shaped by individual circumstance. By framing the research in lived experience, the findings highlight community needs, behaviours and the barriers that influence how people navigate everyday life and health needs.

While the findings reflect a range of experiences, they do not represent every voice within the community. However, they offer important insights that can inform more accessible service delivery and support improved health outcomes. The challenges identified are not new, and without action will continue to impact people's health and wellbeing.

In Crawley the Chagossian community more recently is over represented in temporary accommodation, reflecting the direct impact of Government policy changes. Without adequate infrastructure at community level, this risks embedding health inequalities which this project found amongst residents who migrated in previous decades. To address this, greater investment is needed to meet both existing and emerging needs, with a focus on specific health issues such as HIV and hepatitis. Improved data collection, recording specific groups, could help identify trends in conditions like diabetes and hypertension, enabling more targeted interventions.

Addressing these challenges requires collaboration between statutory services, local authorities, community organisations, and community members, working together to create a system that recognises and responds to the needs of its residents. By building on the community's resilience, mutual support and lived experience, there is an opportunity to develop services that are more accessible, trusted and capable of addressing health inequalities.





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